



MT. HOOD KIWANIS CAMP
for Children and Adults with Disabilities
9320 SW Barbur Blvd., Suite 165
Portland, OR 97219
503-452-7416, ext 104
registration@mhkc.org
www.mhkc.org

Summer Application & Directions

1. Completely fill out, sign and date where requested:
 - Camper Application, page 2
 - Acceptance Criteria & Agreement, page 3
 - Camper Information, pages 4 and 5
 - Health History, pages 6 - 10 with physical exam completed by a licensed health care provider on the lower portion of page 9 - The licensed health care provider portion is not required if the camper has had an exam within the past 2 years, and the signed form is on file at the Camp Kiwanis office. If in doubt, call the number above.
 - Please send a recent picture of your camper along with your application.
2. Mail all* of the above forms with the deposit of \$100 to:

Mt. Hood Kiwanis Camp
9320 SW Barbur Blvd., Suite 165
Portland, OR 97219

***Note: The health form can be mailed later, but must be received at least one month before the camper attends camp. Please DO NOT WAIT until the last minute to schedule the doctor appointment if it's necessary. Call 503-452-7416 Ext. 104 if in doubt. The doctor MUST have examined the camper within 2 years of the date of camp attendance (not just the date he signed the form.)**

3. You will be notified by mail when your camper has been accepted. The notification includes the camper's assigned camp week and arrival time along with a map to camp and a list of what to bring. **The pickup time will be 11AM on Friday.**
4. The balance of the camp fee is due 30 days from the date of the acceptance letter.

PLEASE NOTE:

- Your application (pages 2-10) must be complete to be considered. If you are requesting a campership (the maximum award is \$275), call the office for an application or download from our website.
- Acceptance is on a first-come first-served basis providing the applicant meets the acceptance criteria noted on page 3 of the application.
- Applications are accepted as long as spaces are open. Apply promptly; weeks fill quickly. **You may sign up for only 1 week.** After May 1, you may select a second week if one is available.
- The health form must be sent to the Portland office as soon as possible, and at least one month before the camper attends camp. Registrations are subject to cancellation if the forms are not received on time.
- If cancellation is necessary, notify the camp office at 503-452-7416 Ext. 104 as soon as possible. A \$75 processing fee is charged for cancellations. No shows will be charged the cancellation fee. If the camper is a 'no show' 2 years in a row, any future registrations will be denied.
- If you have questions regarding this application or the process, call the camp's office at 503-452-7416 Ext. 104.

Keep this sheet for your records

2010 CAMPER APPLICATION

Please print in blue or black ink

Camper's Last Name _____ First _____ Nickname _____

Camper's Home Address _____ Check if new address

City, State, Zip _____ County _____

Male Female Date of Birth: Month _____ Day _____ Year _____ What will the camper's age be at camp? _____
(Must be 9 years old by June 1, 2010)

Camper T-Shirt Size: Small Medium Large X-Large XX-Large XXX-Large

Is camper own guardian? Yes No Is camper in foster care? Yes No Ethnicity (optional) _____

Parent/Guardian name _____ Home Phone (____) _____ Cell Phone (____) _____

Parent/Guardian address if different from above _____

City, State, Zip _____ Email _____

Employer name _____ Work Phone (____) _____

Second Parent/Guardian name _____ Home Phone (____) _____ Cell Phone (____) _____

Second Parent/Guardian address if different from above _____

City, State, Zip _____ Email _____

Employer name _____ Work Phone (____) _____

Where would you like to receive mail regarding registration news and information? Camper home address Parent/Guardian address

Emergency contact other than above 1. _____ Relationship _____

Daytime phone (____) _____ Evening phone (____) _____ Cell phone (____) _____

Emergency contact other than above 2. _____ Relationship _____

Daytime phone (____) _____ Evening phone (____) _____ Cell phone (____) _____

Weeks: (1) June 20-25; (2) June 27-July 2; (3) July 4-9; (4) July 11-16; (5) July 18-23; (6) July 25-30; (7) Aug. 1-6; (8) Aug. 8-13

	First Choice (circle one week)								Second Choice (circle one week)								
Main Camp	1	2	3	4	5	6	7	8	Main Camp	1	2	3	4	5	6	7	8
Canoeing			3C	4C	5C	6C	7C	8C	Canoeing			3C	4C	5C	6C	7C	8C
Trip & Travel	1T	2T	3T	4T	5T	6T	7T	8T	Trip & Travel	1T	2T	3T	4T	5T	6T	7T	8T

Fee Information:

For Main Camp and Canoeing	Camp Fee\$750	For Trip/Tent & Travel Camp	Camp Fee.....\$800
Due with this application	Deposit\$100	Due with this application	Deposit.....\$100
Due one month after acceptance	Balance\$650	Due one month after acceptance	Balance.....\$700

A caregiver attending camp with a camper will be charged \$25 per day.

If you need a receipt of payment, please enclose a stamped, self-addressed envelope. To apply for a campership, either download the form from the website or call the office to have a form mailed to you. The maximum campership available is \$275. A camper may receive only one campership per year. If an agency or source other than the camper's family is paying the camp fees, please complete the following information:

Agency name: _____ Payment amount \$ _____

Contact: _____ Phone: (____) _____

Address with city, state, zip: _____

The release on the next page must be signed by parent or guardian

FOR OFFICE USE: Rec'd _____ Dep _____ Notes _____

Camper's Name: _____

ACCEPTANCE CRITERIA AND AGREEMENT

Please read and sign this page

Mt. Hood Kiwanis Camp, Inc. accepts applicants regardless of race, color, national origin, sex, sexual orientation, veteran status or disability. The following criteria are used to determine acceptance: The applicant (1) must be able to benefit from the camp program, (2) must be adaptable to the group living environment, (3) must not be physically, verbally, or sexually abusive, (4) must have no history of arson or fire setting AND (5) must be free of conditions and behaviors that might not be manageable in a camp setting. (See Program Eligibility Standards)

We (camper and parent/guardian) wish the applicant who signs below to participate in the Mt. Hood Kiwanis Camp program. We recognize that there may be risk of injury during such participation and that certain dangers and accidents may occur. We further agree that each person participating in the program must follow safety instructions, remain in areas designated by staff, and refrain from behavior that is harmful to himself/herself or others. Failure to do so will be cause for the camper's dismissal from the program. Please be aware that all of Mt. Hood Kiwanis Camp's employees and volunteers are mandatory reporters. Any concerns or allegations of abuse will be reported directly to Department of Human Services and not to the parents or caregivers of the camper.

In consideration of participation in the program, the camper and the camper's parents hereby release and discharge the Mt. Hood Kiwanis Camp, Inc., its officers, agents and employees; Kiwanis Clubs and their members; Portland State University, its employees and students; the State of Oregon; the U.S. Forest Service and the agents and insurers of each of them, from any and all claims, arising from negligence including but not to exceed ordinary negligence as allowed by Oregon state law, or breach of contract, because of any injury to the applicant during participation in the program. Further, we agree to defend and indemnify the Camp, its officers, agents and employees; Kiwanis Clubs and their members; Portland State University, its employees and students; the State of Oregon; the U.S. Forest Service and the agents and insurers of each of them, from actions for damages or expense caused to other participants in the program which are caused by our camper.

I give permission for the Camp Director or his/her designee to search camper's belongings, with camper present, when the health, well-being or safety of the camper or others requires a search.

I give permission for camper to be transported in camp-designated vehicles for off-site trips and for emergency or routine medical care.

I understand that the Mt. Hood Kiwanis Camp must provide a safe and cooperative group experience for all campers and that the applicant may be dismissed from the program for reasons including behavior, illness, injury or homesickness.

I understand that any refund for a camper leaving the camp early will be prorated based on the number of nights spent at camp.

I have read and understand the fee structure, refund and balance-due policies and agree to pay as stated.

I do ___ do not ___ give my permission for my camper to call me collect from camp.

I understand that photographs may be taken at the camp showing the campers and camp staff in their usual camp activities. Some photographs will be used by Mt. Hood Kiwanis Camp and Portland State University for both promotional and educational purposes in printed materials, on our website and in other media. I also understand that other parents, guests, staff, and volunteers will be taking pictures as well and it is out of Mt. Hood Kiwanis Camp's control to monitor the use of these pictures.

Yes, I agree that Mt. Hood Kiwanis Camp, Inc. and Portland State University may take photographs of campers in usual camp activities and that the pictures may be used for the above purposes as deemed proper by Mt. Hood Kiwanis Camp, Inc. and/or Portland State University.

Initial here if you give permission: _____

No. I do not give permission for Mt. Hood Kiwanis Camp, Inc. and Portland State University to use photographs of the camper for promotional or educational purposes.

Initial here if you do NOT give permission: _____

I DO HEREBY ACKNOWLEDGE that I have carefully read all of the foregoing information and I understand and agree to its contents.

x _____
Signature of Parent or Guardian

Date

I understand and agree to follow the policies of the Mt. Hood Kiwanis Camp and any restrictions placed on my camp activities.

x _____
Signature of Camper

Date

Camper's Name: _____

CAMPER INFORMATION

The person completing this form is a: camper relative guardian agency staff member group home staff foster parent

If staff member, name of agency or group home _____ Email address _____

Agency/group home contact _____ Phone number (____) _____

What is the camper(s) disability/diagnosis? _____

Mobility

Is the camper completely mobile? yes no

Does the campers use a

Manual wheelchair yes no

Powered wheelchair? yes no

walker? yes no

crutches? yes no

braces? yes no

Will the camper be bringing any other mobility aid?

Can the camper transfer from wheelchair? yes no

How can we help with mobility?

Sensory

Is the camper blind? yes no

have partial vision? yes no

wear glasses? yes no

Communication

Does the camper communicate through

speech? yes no

gestures? yes no

signing? yes no

read lips? yes no

communication board? yes no

eye gaze? yes no

Is the camper deaf? yes no

wear hearing aids? yes no

Does the camper:

respond to his/her name? yes no

have intelligible speech? yes no

Does the camper communicate in any other way?

Please explain common directional cues or commands:

Behavior/Personality

How does the camper express anger? _____

How does camper express fear, anxiety or confusion? _____

What techniques can we use to comfort the camper? _____

Social Interactions

What situations cause fear or anxiety for the camper?

Does the camper make friends easily? yes no

How does the camper interact with others? _____

What are the camper's greatest strengths/qualities? _____

Additional Information

Camper's Name: _____

Does the camper have any issues with self-abuse or aggression towards others? If yes, please explain.

What circumstances may cause the camper to run away from the group? _____

What specific interests does the camper have?

What other information may be helpful in providing a successful experience for your camper? _____

Day & Night Routines

Does the camper

shower independently? yes no

shave independently? yes no n/a

wash hands & face independently? yes no

dress & undress independently? yes no

brush teeth independently? yes no

groom hair independently? yes no

care for menstrual needs? yes no n/a

If answering 'no' to any of the above seven questions, how can we help with these morning/evening routines? _____

Does camper use the toilet independently? yes no

If yes, how does the camper communicate the need to use the toilet?

What assistance does camper need to use the toilet? _____

Does camper have daily bowel movements? yes no

If no, please explain? _____

Does the camper

sleep walk? yes no

wet the bed? yes no

frequently awaken in the night? yes no

have night terrors or nightmares? yes no

If answering 'yes' to any of the previous four questions, how should we care for camper? _____

Is there any reason why the camper cannot share a room with another camper? yes no

If yes, explain _____

Does the camper have any bedtime rituals that should continue at camp? If yes, explain _____

Will or does the camper take naps? yes no

Meals

Does the camper

eat independently? yes no

require assistance cutting food? yes no

drink from a glass independently? yes no

self finger-feed? yes no

Does camper tend to overeat if allowed? yes no

If the camper needs assistance with eating, how can we provide it?

Does the camper have a special diet? yes no

If yes, explain _____

Does the camper have any food allergies? yes no

If yes, describe _____

Does the camper eat three meals a day? If no, describe _____

Sensory

Does camper have sensory issues? yes no

If yes, what sensory issues does the camper have?

Auditory _____

Tactile _____

Visual _____

Does the camper benefit from any of the following?

swinging rocking other

If yes, explain _____

Mt. Hood Kiwanis Camp Health History and Examination Form

Please give complete information below so the camp is aware of your camper's needs and has the information necessary for appropriate care. If there are changes after you send us the form, please notify the nurse upon arrival at camp.

Camper Last Name _____ **First** _____ **Nickname** _____

Birth date _____ Age at camp _____ Social Security # _____ [] Male [] Female

Custodial parent/guardian _____

Home address _____ City, State, Zip _____ Home phone _____

Business address _____ City, State, Zip _____ Business phone _____

Second parent/guardian or emergency contact _____

Home address _____ City, State, Zip _____ Home phone _____

Business address _____ City, State, Zip _____ Business phone _____

Group home name _____ Manager _____ Phone _____

If above persons are not available in an emergency, notify:

Full name _____ Relationship to camper _____ Business phone _____

Address _____ Home phone _____

Family Physician _____ Phone _____

Dentist/Orthodontist _____ Phone _____

Is the camper covered by medical/hospital insurance? [] Yes [] No

If yes, give carrier or plan name _____ Policy/Group # _____

Name of insured/relationship to camper _____ Insurance ID # _____

AN IMPORTANT MESSAGE REGARDING MEDICATION WHILE AT CAMP

PLEASE READ THIS MESSAGE EVEN IF YOUR CHILD DOES NOT TAKE ANY PRESCRIBED MEDICATION. POLICIES REGARDING THE ADMINISTERING OF NON-PRESCRIBED MEDICATION AS WELL.

Dear Parents/Caregivers-

This letter is designed to give you information regarding the administration of medication at Mt. Hood Kiwanis Camp. A registered nurse will administer all medications at Camp. During check-in **YOU MUST WAIT IN LINE AND GIVE MEDICATION DIRECTLY TO THE NURSE.** During this check-in you will be able to discuss any medical questions you may have and to give any special instructions about the administration of medicine to your camper. An individual medical log sheet will be completed for any medication provided. You will be asked to review and initial this log sheet with the nurse. The following guidelines have been established to ensure the safe and proper administration of medicine.

IF YOU ARE BRINGING YOUR OWN MEDICATION:

1. Each medication, including over-the counter medication and vitamins must be in its original container with the proper label.

2. For prescription medications, the prescription must be current (within 1 year), in the camper's name and with the proper instructions. If the instructions/dosages have changed, you must provide a doctor's note stating the new instructions/dosages.

3. Please send extra pills/liquid medication in the event that medication is dropped or spit out and becomes unfit for administration.

4. If your camper needs special equipment (e.g. a certain cup or straw) or food other than applesauce (e.g. pudding or yogurt) to take medication, please bring these to camp in the original container, labeled with camper's name.

PLEASE NOTE THAT ITEMS 1 & 2 MUST BE MET IN

ORDER FOR YOUR CAMPER TO ATTEND CAMP!

OVER THE COUNTER MEDICATION ADMINISTRATION

In addition to the medications you provide for your camper, Camp nurses have standing orders to administer certain over-the-counter-medications. These medications are listed on page 5 for your review. There are two options that you may choose from. You may change this choice at any time.

Please complete ONE of the two options. In most cases the nurse will not call when these medications are given. However, you would be notified right away if your camper is seriously ill or does not respond to over the counter medication. The administration of these medications is documented in the Camp treatment log. Complete option 2 on the reverse side if you would like to be notified prior to the administration of these medications. Please note that this option may cause a delay in your camper's symptoms if you are not readily available.

This Box Must be Complete for Attendance

Parent/Guardian Authorizations: This health history on both pages is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any record necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for this participant. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the participant. I also agree to be responsible for any expenses which may be incurred in providing emergency medical or surgical treatment to this participant. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper _____

Printed name _____

Date _____

Camper's Name: _____

Have/has the camper:	Yes	No		Yes	No
1 Recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	12 Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
2 Have a chronic or recurring illness?	<input type="checkbox"/>	<input type="checkbox"/>	13 Been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
3 Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	14 Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
4 Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	15 Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
5 Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	16 Ever had problems with joints?	<input type="checkbox"/>	<input type="checkbox"/>
6 Had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	17 Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7 Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	18 Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
8 Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	19 Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
9 Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	20 Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
10 Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21 If female, abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11 Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22 Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
			23 Required psychiatric treatment?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any 'yes' answers, noting the number of the questions: _____

Attach additional pages if necessary

Allergies: List all known allergies. Describe reaction and management of the reaction. Attach additional page if necessary.
Medication allergies: _____

Other allergies (include insect stings, hay fever, asthma, animal dander, etc.): _____

Food allergies: _____

Will this camper need a special diet? If so, please provide all necessary food for this camper for the week. IE Gluten and Casein free diets

Medications Being Taken: List ALL medications including over-the-counter or non-prescription drugs taken routinely. Bring enough to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. This list will aid the health care staff at camp, so while we realize that these might change please fill out entirely.

This person takes **NO** medications on a routine basis.

Name of Prescription	Dosage	Time Given

Name of PRN (as needed)	Dosage	Reason for Medication

Name of Vitamin/Supplement	Dosage	Time

Camper's Name: _____

Immunizations, please attach sheet if necessary

Check if participant has had:

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Date of last TB Mantoux Test _____
- Result: Positive Negative

Please give all dates of immunizations (write 'none' if not immunized):

Vaccine	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____
Hepatitis A		_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____
BCG		_____	_____	_____	_____	_____

To Be Completed by Licensed Health Care Provider

I have examined the above-named camp participant within two years prior to camp attendance. Date examined: _____

In my opinion, the above applicant is is not able to participate in an active camp program.

Height _____ Weight _____ Blood Pressure _____ Diagnoses _____

The participant is under the care of a physician for the following conditions: _____

Recommendations and Restrictions while at Mt. Hood Kiwanis Camp

Treatment to be continued at camp _____

Medications to be administered at camp (name, dosage, frequency) _____

Any medically prescribed dietary restrictions _____

Known allergies _____

Describe any limitation or restriction on camp activities _____

Does this person have a positive diagnostic x-ray for Atlantoaxial Dislocation Condition? ____ If yes, give activity restrictions relating to horseback riding adventure course, etc. _____

Please attach additional information that may assist health care staff at camp.

Signature of Health Care Provider _____ **Date** _____

Printed Name _____ Phone _____

Address _____

Please send to Mt. Hood Kiwanis Camp Office, 9320 SW Barbur Blvd. Suite 165, Portland OR 97219-5430

Camper's Name: _____

Camp Physician Standing Orders

At times, it maybe become necessary to treat minor ailments from our Camp Physician Standing orders. The following medications may be used. Please indicate whether these medications are acceptable to give your camper under the direction of the Mt. Hood Kiwanis Camp Standing Orders.

MEDICATION	YES	NO
Benadryl or Generic Equivalent (for allergic reactions and sleep)		
Aloe Vera Gel		
Antibiotic Ointment (e.g. Neosporin)		
Calamine Lotion/Caladryl		
Cough Syrup		
NyQuil (over 12 years old only)		
DayQuil (over 12 years old only)		
Cough Drops		
Dulcolax tabs (for constipation)		
Glycerin or Dulcolax suppository (for constipation)		
Epinephrine (for serious allergic reaction)		
Fleet Enema		
Head Lice Shampoo		
Hydrocortisone Cream 1%		
Advil/Ibuprofen		
Tylenol or Generic Equivalent		
Ematrol or Generic Equivalent (for nausea)		
Sarna Lotion		
Motrin or Generic Equivalent		
Midol or Generic Equivalent (for menstrual cramps)		
Ivy Dry/Ivy Stat or Generic Equivalent (for poison oak)		
Kaopectate		
Milk of Magnesia		
Pepto Bismo (for upset stomach, nausea, or diarrhea)		
Rash Ointments (e.g. Destin)		
Solarcaine		
Saline-for eyes		
Swimmer's Ear or Generic Equivalent- water drying drops		
Sunblock		
Auralgen ear drops (earache)		
Bug Spray		
Aspirin		
Tums		

I authorize the Mt. Hood Kiwanis Camp to administer the medications listed on the Camper Medication Record page according to the manufacturers' written instructions. The medication information given today supersedes any previous information given at the time of registration.

I authorize the Mt. Hood Kiwanis Camp to administer any of the above medications indicated "yes" according to the Camp Standing Orders, as necessary for minor ailments.

Parent/Guardian/Camper Signature: _____ **Date:** _____